MR. BARRON: (ten: 27 a.m.).
MS. CHABER: I would like to note that this deposition was scheduled to start at ten o'clock. At approximately nine 20 my office received a telephone call that the office of shook Hardy didn't have the x-rays here that this doctor had reviewed and that if we wanted to bring our x-rays along to question him about it, that would be fine and that his opinions would be consistent with the report or the notes that he had written previously. I'd like to note for the record that I did not receive those notes until nine 45 a.m. today prior to the start of this deposition and that I spent the next 25 minutes looking for the x-rays in our office only to learn that they had been sent elsewhere because as has every deposition of a medical doctor to date proceeded, there have been x-rays at that deposition generally at the place where the deposition has taken place or discussion prior to that as to who was bringing the x-rays and making them available. I also like to note that I have repeatedly requested any notes or reports and I have repeatedly been told over and over that there were none and apparently there are notes that were created on November third from doctor hensly and

then updated on the 14th of December. I would note that none of them have been provided prior to basically 15 minutes before this deposition was to start. I think that counsel has both violated the code and the spirit of expert discovery in this case. I would like to have copied and attached for the record a fax transmission from today along with the fax notes that doctor hens as plaintiffs first in order. The notice of taking of the deposition for doctor hencely for December 18th and finally doctor what is your hour charge for depositions.
MR. BARRON: Before he answers that let me just respond very briefly. I am not going to respond {SAEUR} at a.m. {PR*EPB} to each of the things that you mentioned but I will indicate that the call was made because it was not appreciated by me until I made the call that the x-ray films that he had looked at were not available in this office because we had apparently sent it off to some other physician and that's why I called among other reasons to alert you to that to bring your films which I assume you did I'm sorry you don't have them. I don't think it would be that issue a practical problem for you because of the fact as I indicated to you during the phone call his views or

opinions about those films are not -- my view at least (in) at variants or substantially add variance with what I said was the x-ray reports which you've had presumably any anybody of us and reports by the radiology in terms of the notes that he made you are not accurate in some of the assumptions you made in making your statement he would be happy to describe

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the circumstances of those notes when they were made and the extent to which if at all this office was aware that he had them. Other than that you now can make your record about the check with him and do whatever you like that follows.

MS. CHABER: Before I get to that we had a discussion last Wednesday with respect to the areas that the doctor was going to be offered in and those areas were and I have them written down as I wrote them at the time autopsies death certificates pathology and anatomy and I object to this sudden inclusion of x-rays which were obviously reviewed more than a month and a half ago and that information not pursued by counsel in light of the fact that I haven't been asking for reports or notes since the start of this and that expert disclosure or expert note exchange was due on (have) I believe November 16th and obviously subsequently to whenever

counsel receives materials or inquires from their experts about materials.

MR. BARRON: If you finished with that comment I suppose I should respond to one thing mentioned I did try to provide you heads up of what I thought were the major pertinent areas of his opinions. I obviously like in any other situation did not at that time take the time with you to tell you everything that he had looked at I wouldn't have been able to do that because I wasn't aware of everything at that time nor would I have taken the time to do that had I have been aware nor you expected me to do that there was no expectation binding than heads up of what I thought were the major areas I thought he had opinions about in all situations it doesn't mean he doesn't have additional opinions that are either sub opinions of those opinions or are opinions that are not as a major significance because of his background as the ones I gave you heads up on so I don't know what you are trying to imply there about me giving you those four areas but if it's anything more than what I just said I think we better be clear before you ask for a heads up then in the future or I better be more reserve about getting you one.

MS. CHABER: Are you done?

MR. BARRON: Sure.

MS. CHABER: Doctor how many do you charge per hour for deposition testimony?

A. 300 dollars.

Q. And how much do you charge for consultation time?

A. For examination of a case 250 dollars that's not per hour it's for the case.

Q. Somewhere along the line apparently we were advised that your hourly was 400 an hour I'm handing you a check for 800 dollars. I'm sure we will be able to though not particularly by my math but be able to calculate out based on 300 an hour?

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A. May I make a comment about that.
Q. Yes.
A. The misunderstanding is probably based on the fact that I believe I stated earlier that I charge 400 dollars an hour for trial testimony normally I charge 300 dollars an hour for testimony at deposition.
Q. Okay. Thank you for that qualification. Doctor have you ever been deposed before?
A. Yes, I have.
Q. On how many occasions?

A. Well, I can't give you an exact number. I would put it this way: For many years when I was a faculty member at the university of Miami I would review cases and be deposed maybe oh, between two and four to five times a year. So for like the 25 year period and I just don't keep exact numbers so that's the best I can do.
Q. We are at the end of 1998 how many times have you been deposed in 1998?
A. In 1998?
Q. Yes.
A. Twice.
Q. And before I go further into this let me introduce myself my name is mad Lynn Chaber and I represent Patricia henly in her suit against pill incompetent {PHORS}?
A. It's a pressure to meet you I'm wearing these dark eye {TKPWHRAZ} because of recent eye surgery normally I don't look at people out of dark glasses.
Q. I appreciate that I'm looking straight into a very bright window I think I should be wearing the dark glasses as well but I appreciate you telling me that?
MR. BARRON: Do you want us to pull the

blinds?
MS. CHABER: No and lose my beautiful bay bridge view not a chance.
Q. Doctor, the two cases that you were deposed in in 1998 can you tell me about those two cases?
A. Each of them related to testimony in regard to cancer of the lung and issues related to the smoking and cancer of the lung.
Q. And at whose -- I take it you were an expert witness in each of those as opposed to a treating physician?
A. That's correct.
Q. And at whose request were you an expert?
A. The firm of shook Hardy and back on.
Q. And who do you understand shook hard and bacon to represent?
A. Well the representative of the firm I most commonly con fir with include Mr. Curtis pear {PR*EPB}, Mr. Thomas A did you know {KA*PB} and occasionally others.

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Q. You've given me attorneys names?
A. Yes ma'am.
Q. And you've given me the name of a law firm, correct?

A. They represent the law firm of shock Hardy and bacon.
Q. These are lawyers from the lay firm of shook Hardy and bacon who do you understand the defendants to be in the cases that you were deposed in in 1998?
A. I honestly don't know.
Q. You do understand that shook Hardy represents cigarette company?
A. Yes and furthermore I understand that these cases involve particular tobacco companies but if I ever bothered to find out the names of the particular tobacco companies I don't recall them at the moment. That is not normally important to me.
Q. But you do understand that it is tobacco companies even though you don't know the particular whether it's Philip {PHORS} or some other company?
A. My understanding of that is is quite clear.
Q. And when is the first time you were consulted by lawyers who represented the cigarette company?
A. Well, as I recall and I don't want to pretend to be highly exact, it was in 1995.
Q. And how did that come about?

A. I was visiting in Miami Florida and a contact of some sort between the aforementioned firm and one of their attorneys Mr. Anthony an dray was made and I met with Mr. An dray {PR*EPB} in offices in Miami together with some of his associates and he asked me to render a diagnostic opinion about a particular case that they were considering. I agreed to do that and I examined the hiss tow logic {PRERPGSZ} under the microscope and gave my diagnosis on the case. He asked me if I would be willing to do similar consultations in the future and I relied firm I feel the reason that he contacted me and said I had been recommended by the chairman of the department of pathology at the university of Miami back A Z O R I.D. E S MO R A L L E S (back with).
Q. And at the time you were contacted in 1995 were you retired?
A. Yes. I had just retired that year.
Q. And how many times since 1995 with this first contact have you been contacted to consult with someone representing a tobacco company?
A. Quite a few although I really wouldn't be able to tell you precisely how many without looking it up. I suppose two or three times a month I'm

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presented with pathological materials which is to say slides prepared for microscopic examination and/or cytology specimens and ask for my diagnostic opinion on those materials.

Q. And on how many of those cases that you were consulted in the two or three approximate times a month since 1995 have you been deposed?

A. I believe only twice.

Q. And those would be the two in 1998?

A. Yes ma'am.

Q. And this would represent the third in 1998?

A. To the best of my recollection. I must tell you that I'm not sitting here saying I have a steel trap mind for numbers but I believe it's only two.

Q. And have you testified in a court of law at any time?

A. Yes ma'am.

Q. How many times?

A. I think five times.

Q. Since what -- when was the first time?

A. Well, the first time I actually testified in Florida in a court of law was probably about 1990.

Q. And what type of case was that?

A. That was a medical malpractice action.

Q. Had you been involved at all in the treatment, care or treating diagnosis of the individual involved?

A. No.

Q. And you were called in to testify as an expert?

A. Yes.

Q. By whom?

A. By the attorney representing the plaintiff Mr. Stanly Rosen {PWHRAT} {PR*EPB}.

Q. And have you testified or been deposed at any other time where Mr. Stanly rows {PWHRAT} was involved?

A. Yes.

Q. How many times?

A. Once excuse me twice. I'd like to clarify that if I may. About 1996 I testified on behalf of the defendant surgeon at the university of Miami school of medicine. The plaintiff's case was being handled by the firm of Mr. Stanly rows {PWHRAT} so this time I was on the opposite side of the fence with respect to his firm. The other time actually relates to one of the tobacco depositions

that I have given this year. I believe I gave a general deposition in a matter that he is handling a court in Miami Florida at the present time.

Q. And that's the E N G L E case?

A. Yes that's the case.

Q. And were you on the same side as Mr. Rows {PWHRAT} or the opposite side?

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A. I was on both sides.
Q. In the evening he will case?
A. In the evening he will case I will be testifying for the firm of shook hard and bacon and I can't tell you all of the defendants name in that case I just don't remember.
Q. You understand that to be a class action -- a case for six smokers in Florida?
A. I understand that.
Q. And in that case are you charging for consultation with the tobacco companies 250 dollars for the -- as a general one case or some other amount?
A. No ma'am. I have not to the best of my recollection have been asked to render diagnostic opinions on specific individuals involved in that class action suit so I am not charging for that service. I do make a charge for preparation, for

consulting on cases that may come to trial that charges 85 dollars an hour for reviewing medical records and/or pertinent medical literature, other things that I must do to prepare myself for conference in this matter and that's the charge I make.
Q. And in the angle case how much have you charged to date?
A. I can't tell you naturally I have that information that I could retrieve but I really don't know.
Q. Do you know how many approximate hours you put in for preparation in the angle matter?
A. No if I did I could compute the charge around the basis of 85 times the number of hours but over the last year or perhaps a few months longer than a year from time to time I've worked on that while I've worked on other matters unrelated to tobacco or shook Hardy and I just haven't kept that information in my head.
Q. Is it more than a day?
A. Oh, yes.
Q. More than a week?
A. I really couldn't sum the time but I can tell you that the total billing with respect to the

angle case is probably on the order of magnitude of maybe five or six thousand dollars I want to emphasize that it's a rough estimate I'm giving at your request to vary a little bit.
Q. And you do have have information maintained somewhere?
A. Yeah I keep a daily log I just write down what I do for the {PUP} of charging I could compute that.
Q. And is it correct that the angle matter you have not yet testified?
A. That's correct.
Q. And is it also true that before you would testify you would want to do more preparation in the

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angle matter?
MR. BARRON: I'm going to ask what the relevance of this is what he's going to do in another case.
MS. CHABER: I'm entitled to know how he makes his living of what percentage of his --
MR. BARRON: The allow allows you to be that broad in your discovery (I don't think the law {PHREPB} (.
MS. CHABER: How he makes his living vis-a-vis cigarette defendants counsel. This is not

a generalized question it was specific to the angle case.
MR. BARRON: How much more time he may spend how many more dollars he may charge in angle.
MS. CHABER: Yes.
MR. BARRON: Okay.
MS. CHABER: I thought that was the question did you understand that to be the question.
A. I believe that's the way I conceived it.
Q. Okay.
A. Well, let me respond by saying --
MR. BARRON: One answer can lead to a lot of other questions unless you are just responsive she may or may not want you to do that I think the only question is if you have an anticipation of how many more hours you are going to spend or how many more dollars will be charged for that, that's all she's looking for not any other long explanation.
THE WITNESS:
MS. CHABER: I would have been happy to have your long explanation but obviously counsel wants to coach you a little bit about that.
MR. BARRON: I want to move the deposition along so we get to things that are particularly pertinent to the case so we don't have

a time problem on other things.
THE WITNESS: I have some work -- some medical literature to review that's incomplete because of the eye surgery that I had so I'm a little off schedule. I would just estimate that maybe another 10 or 20 hours of literature review might be put in but that might be on the genocide. I'm not sure.
MS. CHABER: How much time have you put in to date on this case the henly matter?
A. Well again I couldn't tell you precisely but I can make a reasonable estimate.
Q. Okay.
A. Reviewing medical records for which I have charged 85 dollars an hour probably around 3 hours. I charged 250 dollars for reviewing the slides in my office in Virginia. I charged 300 dollars to come to San Francisco and confer with the attorneys here at shook Hardy and bacon when I once again reviewed the slides and some x-rays. I did not make an additional charge for reviewing the

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slides a second time, just once and that's the extent of the charges until this trip.
Q. Okay. This trip to San Francisco was that on an occasion other than for this deposition?

A. No it's for this deposition.
Q. And when did you arrive?
A. Yesterday.
Q. And when did you review the x-rays?
A. That was on the prior trip and the answer to that is November third, 1998.
Q. When you say on a prior trip that you reviewed x-rays, was that a prior trip to San Francisco?
A. Yes ma'am. Perhaps I was not clear but charge the last series of charges that I recounted was in connection with that trip. That's the charges where I said I'd charge 300 dollars for the trip, that was the trip of November third.
Q. Now you spent time yesterday with the attorneys?
A. I did.
Q. And how much time did you spend?
A. As I recall it was from 4 until -- excuse me, I'm confounding east and West Coast times. It was from one o'clock until five.
Q. And who did you meet with?
A. The attorneys in this room and Ms. Jane ass man.
MR. BARRON: When you say attorneys in

this room she is the type who wants to be very specific I wasn't here was I.
THE WITNESS: Pardon me that's right you weren't.
MR. BARRON: You have to be very careful because she tends to think in this very scientific mode in these questions.
THE WITNESS: That's good and I apologize for my error.
MR. BARRON: That's okay we know what you meant.
THE WITNESS: Mr. {KURTS} appear was present and maybe just because of this occasion for some reason I have a mental black about your colleague Curtis who was present also.
MR. BARRON: He can't answer in deposition.
MS. CHABER: He could provide that information.
THE WITNESS: I just don't remember his name at the moment.
MS. CHABER: Mr. {SEURPBLG} do I have to go through a list of the counsel on the shook hard letterhead or do you want to just tell me counsel.
MR. BARRON: We are not.

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MS. CHABER: Willing to cooperate yes.
THE WITNESS: It may come back to me.
MS. CHABER: That's fine.
Q. What was Ms. Ash {PHAFRPBLGTS}?
A. She is the lady situated at the end of the table there.
Q. Is she an attorney?
A. No she's an investigate tore and analyst.
Q. What kind of an analyst?
A. Well her background is in nursing and she provides assistance to the attorneys of shook hard and bacon and their work.
Q. Did she do and provide any assistance to you?
A. Yes.
Q. Can you describe that please?
A. This week she sent me an update of medical records on Mrs. henly.
Q. Did she have any conversations with her about those updates?
A. No we didn't talk. In fact she sent them through someone else's secretary I think.
Q. Have you had any discussions with Ms. Ash man with respect to this case?
A. She's been present during discussions

with the attorneys and there have been some participation but I can't remember more specific than that.
Q. I want to go back for a minute to the two depositions in 1998 both relating to cases where you were an expert on behalf of tobacco company you followed me back to where we went?
A. Yes one of those was the angle case as I mentioned.
Q. And what was the other one?
A. Well you'll have to give me a moment to recollect it. That was a matter in the courts of the state of Tennessee where I gave a telephone deposition with an attorney representing three patients whose causes of action have been placed together.
Q. And -- were those cases pending in Memphis?
A. I think it was Memphis but I'm not completely sure.
Q. Do you remember the name of the attorney who deposed you by telephone?
A. No, I don't.
Q. Does the name well, I never {PR*EPB} sound familiar?

A. That name certainly came up the day I talked with the attorney. It may well be his but it might be somebody else in the firm.
Q. If the name of any of those cases that are pending in ten even come up in your memory, would you advise me during the course of the deposition even if we are on other matters?

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A. Sure.
Q. Thank you.
A. I can tell you one of them a lady by the name of B R U.C. H the others will probably come up as this deposition goes along but I remember that name for sure.
Q. It was your understanding that these cases were put together somehow to be tried at the same time?
A. Yes.
Q. You have a CV?
A. I do.
Q. (do you have) would you provide that to me?
A. If you are going to question me regarding it, I might have to refer to it once again I don't remember all the little dates and details.
Q. Okay.

MS. CHABER: Let's go off the record for a second (eleven o'clock 11:04 a.m. {PHREPB} (.
MR. BARRON: Here's a copy of the curriculum have it tea as I said during the break I would try to find out who met with him. I don't have objection providing that information I just as I mentioned on the brake like to have you deal with me questions like that because of people watching the deposition he said it was pat {SEURPBLG} you can confirm with him that under oath also to clarify U.S. mason wasn't here either who is here in the room today and he can confirm that too under oath if you like and here's his CV.
MS. CHABER: I just needed the information counsel.
MR. BARRON: Okay.
MS. CHABER: So you have your CV back and we will mark but I'm going to use for the time being a copy that was provided to me and I guess we are up to plaintiff's three.
Q. I'm just going to ask you some brief questions about your CV and you have a copy in front of you?
A. I do, yes.
Q. So during the time period that you were a

professor at the university of Miami school of medicine which was from 1975 to 1995 did you ever attain chairman ship of any department?
A. No in fact during that time I rejected an offer to be considered as chairman of adept of pathology at the medical college of Wisconsin in Milwaukee the search committee approached me to be a candidate for that position and I rejected it.
Q. And what was the reason you rejected chairman ship?
A. I don't like to do administrative work. I look at myself as a person who does diagnostic services and teaching and research and I thought administration would get in my way.

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Q. Not a decision I take it you regret?
A. Oh, no. I didn't have to think about it and I was very happy to make it. You'll also note that there's a variation in the administrative positions I held within the department and the reason that {SRAERPBGS} is there for the same reason is when I felt a responsibility to assume administrative duties, I did and as quickly as I could replace myself with someone else I would get out of it and do other things.
Q. Is your -- the CV you have provided up to

date?
A. Yes.
Q. Any additional publications which do not appear on your CV?
A. Let me just double-check here. No.
Q. And --
A. Excuse me, there are a few publications that don't appear on this bibliography but they are not recent vent age.
Q. And why are they listed?
A. Well, things fall through the cracks and there was a monograph on chapter four on mall Ash {STKORPGS} disease and there were a few little articles here and there that I coauthored that I just didn't bother to get into the bibliography. I just didn't think it was all that important sometimes I would forget to put it in. I just didn't bother to correct it.
Q. Am I correct that the bibliography is in descending order from --
A. Inverse order.
Q. Inverse order from the most recent to the longest ago?
A. Yes.
Q. Okay. Since you have been retired have

you authored or coauthored any publications or any articles?
A. I think some have appeared. Yes one with a bright bill in 1996 and --
Q. That's No. 1?
A. No. 1 on the bibliography and also No. 2 they have appeared since my retirement.
Q. Were those --
A. Naturally the work was done before I retired but they were published subsequently.
Q. They had already been submitted and awaiting either exception or publication prior to the time you had retired?
A. That is correct.
Q. (acceptance) and the work that was done on them prior to the time you retired?
A. Yes ma'am.
Q. Okay. Have you ever you know the risk of having to sit here going through each publication have you written any articles on the differential diagnosis between a small cell lung cancer and small

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cell thymic cancer?
A. No.
Q. Have you written any articles on thymic cancer?

A. No.
Q. Have you written any articles on lung cancer?
A. No.
Q. Have you ever diagnosed a primary thymic small cell carcinoma?
A. Not a small cell carcinoma, no.
Q. What type of thymic cancer have you diagnosed?
A. Well, I've seen a number of thymic carcinomas over the years and I haven't really kept track of them in terms of cell type but the two types that I remember diagnosing from time to time were {SKAEUPLS} cell carcinomas and so-called mucoepidermoid carcinoma.
Q. And were the two thymic cancers that you recalled just now --
A. Excuse me I didn't recall two thymic cancers. My response to you was on the predominant cell type naturally I've seen more than two thymic cancers but I was talking about the cell types which I thought was your question.
Q. How many primary thymic carcinomas have you diagnosed?
MR. BARRON: Of any cell type.

MS. CHABER: Of any cell type.
A. I never kept the numbers not a large number I really don't know.
Q. What do you consider not a large number?
A. Oh, probably less than a dozen.
Q. And of those less than a dozen am I correct in understanding that none of them were of the small cell variety?
A. Yes you are correct.
Q. I always hate when I ask questions like that.
A. Well it makes it very exact.
Q. And of the approximately less than a dozen thymic carcinomas that you have diagnosed have all of these diagnoses been after autopsy?
MR. BARRON: You left the word primary out of the question are you changing intentionally.
MS. CHABER: No primary.
THE WITNESS: No.
MS. CHABER: How many were a clinical diagnosis of primary thymic carcinoma?
A. None on the other hand, the final diagnosis on some of them was carcinoma attained during life by means of biopsy.
Q. And how many of these primary thymic

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carcinomas that you have diagnosed were mistaken by other physicians for being a lung cancer?
A. I don't recall if any were or were not.
Q. Can you tell me what the differential diagnosis of the thymic primary lung cancer -- excuse me, I'm mixing too many terms together strike that. Can you tell me what the {KEUFRPB} shall between a lung cancer primary to the lung and a cancer primary to the thymic gland are differential is?
MR. BARRON: You might want to start it over now but if knotty object to the term quote differential closed quote being vague and ambiguous in that question.
MS. CHABER: Do you make differential diagnoses of primary location of cancers?
A. Yes.
Q. Okay. And if I ask you about the differential between the locations of a cancer, do you understand what I mean by differential in that?
A. I don't think I do precisely. When I use the term differential diagnosis with respect to an anatomical site, like other pathologists I would normally mean what are the various types of cancer that originates in the lung for example and then

contrast it with the cancer that may originate in the thymus gland but enumerating those which can occur there. If that's the way you are using the terms, what I can do is say yes.
Q. Okay. So tell me what the -- using your definition of differential what the differential is between cancers primary to the lung and cancers primary to the thymic gland?
A. Well, I don't mean to be obtuse but when you say differential between, it suggests to me that you are asking me how I would distinguish cancers of one organ from those of the other which is different from my original definition but I can certainly go with either frame of reference that you have in mind.
Q. Why don't you answer the latter question now as you understood it?
A. Since some of the cell types that will occur in the thymus and in the bronchus are mike {SKOP}ly indistinguishable I like other experienced pathologists follow the criterion that reliably to distinguish between the two you have to see the site of origin of the cancer which is to say that for example in small cell anaplastic carcinoma originating in the bronchus you have to be able to

demonstrate the origin of the tumor and the bronchial wall if it originates in the thymus, that's a more difficult proposition. You can never be sure of the diagnosis unless you demonstrate its origin within the thymus or if it originates in the rectum for example you have to be able to demonstrate that the small cell anaplastic carcinoma

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originated incite ewe and you do that by looking at the organs with a naked eye and by investigating them by x-rays and so on. The admonition is given in the standard textbooks that you must use those exclusion area criteria before you can be sure of the site of origin of a small cell anaplastic carcinoma to use that particular example.

Q. When you say an a plastic what do you mean by that?

A. An anaplastic tumor is one which has such a simple cellular structure that you cannot recognize any specialized features that give a clue as to what organ or tissue it arose from and that's precisely the problem of differential diagnosis.

Q. Let's assume for the moment that there is some evidence of -- strike that. Let's assume for a moment hiss at that logic diagnosis of the small cell carcinoma okay?

A. In this patient?

Q. In general.

A. All right {SKPWHR} and let's assume that there is some evidence of a tumor in the bronchus and let's assume further that there is evidence of tumor extending into the mediastinal area. How do you differentiate what the origination site is of that tumor.

MR. BARRON: Please hold your answer I need to object to the hypothetical as containing ambiguities such as the phrase quote some evidence closed quote without some clarification what you mean by that and then you go on to say quote of tumor in the bronchus closed quote and not being clear anatomically or paneling owe physiologically what you mean so I think the hypothetical doesn't contain enough preyed cats and becomes ambiguous.

MS. CHABER: Can you answer doctor.

A. Well I would like to answer it on two or three different levels.

Q. Okay.

A. The first level I would like to address the question on is that of a practical practicing surgical pathologist.

Q. Okay.

A. Is not uncommon to be presented with a biopsy from the bronchus and there is an undifferentiated neoplasm involving the bronchial wall and the specimen is so small that you don't have a clearcut indication that it originated in the mucus membrane but you know it could have anyhow and the surgeon may tell you that there is a mediastinal disease. Well, if you look at the x-rays with the surgeon or discuss them with the surgeon whose judgment you are familiar with and you discover that the mediastinal disease they are talking about consists of a number of enlarged lymph nodes in relationship to the bronchi, then you know that the differential diagnosis is sort of narrowed down for

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practical purposes to either a malignant limb foam in the left nodes you are leading into the bran cuss and you've got the biopsy of that or small cell anaplastic carcinoma originate from bran epithelial and met {STAS} I can to the lymph nodes in the mediastinal region which is a very classic presentation of such a tumor. At that level you say to yourself well you are making a diagnosis of an individual patient for whom you are responsible you say to yourself tell the surgeon on the basis of the frozen section I've narrowed the tumor down to an

undifferentiated {TPHAOEP} plasm and I'll do additional studies on it to try to distinguish whether it's limb foam ma or epithelial subsequently and then you would view those studies and finally report it out. The other level I'd like to answer it on is that of a doctor who was not just addressing the narrow question of what the biopsy looks like and try to make a diagnosis there but looking at the patient in his or her totality to make the distinction you want to know for example is the mediastinal disease in your hypothetical case a diffuse cancers invasion involved the tissues or is it in the lymph nodes or is it a single tumor that you can't tell is in a lymph node or not, that kind of information would be necessary to address the differential that you've hypothetically proposed.

Q. And in the case of Ms. Henly do you have any reason to believe that the physicians treating her did not take into account all of the things that you've stated in coming to the conclusion that Ms. Henly had a small cell carcinoma of the lung?

A. No.

MR. BARRON: I need objection vague and ambiguous in many respects include what is meant by the physicians.

THE WITNESS: I've only read the medical record and that information is not contained in it I haven't talked to any of the doctors or even to the pathologists or radiologists so I don't know what their thinking was.

MS. CHABER: You looked at the -- you saw -- strike that.

Q. You saw nothing in the medical records that you reviewed to indicate that the physicians that were carrying for and treating Ms. hen had concluded that she had a small cell carcinoma of the lung?

A. No, I didn't say that. In fact quite the reverse the consensus was that Mrs. henly was suffering from small cell carcinoma of the lung.

Q. Do you have any reason to believe that those physicians did not make that determination taking into account the pathology, the clinical presentation and the x-ray presentation?

A. Well I have some questions about the pathology, for example, if you look at the

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pathologists record, he does not say that she has small cell cancer of the lung. Apparently this man was trained pretty much like I train my own students in my years in teaching surgical pathology. He

didn't answer the question because he didn't see the origin of the cancer there. He left it open. As far as I can tell from that record, it doesn't say anywhere that that small cell cancer originated from that ladies bronchus.

Q. It also doesn't say that that small cell cancer originated from that ladies thymus?

A. Certainly not one can't tell one way or the other from the biopsy.

Q. In fact the question that the doctor referring it to the pathologist was asked what's the cell type isn't that correct?

A. I don't know exactly what he asked him. I have in front of me that surgical path consultation and the question posed to the pathologist according to that document was the patient has a left hilar mass. He did not -- the surgeon did not state his opinion as to the diagnosis and there is not a question about what is the cell type he just simply says I'm giving you a piece of a left hilar mass so I don't know what question was asked.

Q. Could I see the document that you are referring to?

A. Sure. It's at the top.

Q. And you do not dispute the diagnosis of small cell carcinoma in this case correct?

A. I agree with the diagnosis of small cell carcinoma.

MR. BARRON: Can we go off the record just for a second.

MS. CHABER: Sure (off the record (11:30 (11:35 a.m.).

MS. CHABER: Back on the record.

Q. Doctor, during the short break that we took, I had an opportunity to look at your notes and I had thought that what I had attached here as plaintiff's Exhibit 1 which is what was faxed to me this morning as representing your notes was all of your notes. I see, however, doctor that you have four pages of notes, correct?

A. Is it? I don't recall.

Q. I'll give you an opportunity to look.

A. Yes I won't guarantee that I gave these to the attorneys this morning but unjust the four as opposed to three I don't know how many I handed them. It's possible that I only handed them three.

Q. Do you know did you put the staple in the four pages of notes that we are pass being back and forth here with two reports attached to it?

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A. I don't think so.
Q. Do you believe the attorneys put the staple in it?
A. Well, somebody did this morning I believe.
Q. So this morning you gave the attorneys the notes that we've been passing back and forth that are all stapled together correct?
A. I just said I'm not hundred percent sure when I handed them this and exactly how many pages were there but that's a reasonable conclusion I guess.
Q. And the page that I have not been provided appears to have the No. 1 at the top of it and appears to be a review of medical records that you did on October 29th, 1998; is that correct doctor?
MR. BARRON: Let me just make an objection to the preamble the intent was to provide all of them to you by fax that's what I asked I'm looking at a fax cover sheet that indicates what you got with a paperclip with the documents attached to it and the ones that I have before me show that you got the one with the page 1 at the top for what it's worth I'll even show this to you.

MS. CHABER: That's fine.
MR. BARRON: I think I know {SRAD} learnt somehow at your end it either didn't get to you or got misplaced because it even shows the number of pages faxed I don't intend to exclude that.
MS. CHABER: I see that but I don't have the rest so I'll ask counsel to --
THE WITNESS: Would you mind repeat thing the question.
MS. CHABER: I think we've cleared up the issue what I need counsel however are copies of the pages three additional pages that are not attached as plaintiff's Exhibit 1 so it's of the --
MR. BARRON: Why don't you hand to me what you have and I'll get copies of the pages that are missing for some reason.
MS. CHABER: Okay. It starts on page -- I have the first three pages of his notes. It starts on what has the No. 1 at the top that I do not have with the other two being records not his notes.
MR. BARRON: So you only want that one page or the last three.
MS. CHABER: The last pages.
MR. BARRON: Okay. (Ms. Aerobe man

exited proceedings).
MS. CHABER: At least when I'm suspicious I'm willing to admit that I'm wrong.
MR. BARRON: We are halfway there by a few months from now you won't be so suspicious I hope.
MS. CHABER: By few months from now I

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hope this to be over and onto the next of a number of these cases and we will see whether this is a continued suspicion or not.

MR. BARRON: All right.

MS. CHABER: Doctor, have you ruled out that Ms. Had he beenly has a primary small cell lung carcinoma?

A. Not completely.

Q. Can you give me a degree of a certainty with respect to the conclusion that you came to that this was a anaplastic carcinoma of thymic origin?

A. Did I say of thymic origin or probably thymic origin.

Q. With features consistent with thymic origin?

A. I knew there was some qualification there because it's not likely of me to make such an explicit statement. Your questions why did I make

that diagnosis?

Q. My question is with what degree of certainty have you reached that conclusion?

MR. BARRON: Objection as to the phrase quote degree of certainty closed quotas being ambiguous if not potentially logical.

MS. CHABER: Doctor, sometimes you can feel (back) hundred percent sure of an opinion, 80 percent sure of an opinion, 50 percent sure of an opinion, do you understand when I say degree of certainty that that's what I'm asking you for?

A. Let me say that you cannot be hundred percent sure of the diagnosis here because as I said before the actual site of origin is not seen. The degree of medical certainty is difficult term. If you look at the question of diagnoses not confirmed by ah {THOPS} and then compared with the autopsy diagnosis in leading medical centers around the country consistent clinical and pathologic diagnose knees are reached somewhere around 50 to 60 percent of the time. Do I feel that confident in this particular case, no I feel a bit more confident because at least I have seen pretty completely the records of this patient and have a grasp of the anatomy of the lesion in the chest so I would say

I'm more confident than those data and the literature suggests or about prior maybe 75 or 80 percent confident somewhere in that {RA*EURPBG}.

Q. And the 50 to 60 percent I guess concordance between autopsy and clinical diagnosis is that for all diseases or is that specific for carcinoma?

A. I was responding to the question of diagnosis of malignant tumors. Irrespective of whether they are carcinomas or other malignancies.

Q. Let's restrict my question then to carcinomas of the small cell variety. Do you have any data with respect to the concordance between clinical and autopsy diagnosis?

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MR. BARRON: May I have that re.
(Record read)
Read.
MR. BARRON: You mean to add into that question as to the primary site or site of origin or just as to --
MS. CHABER: That wasn't my question counsel my question was, with respect to small cell carcinomas periodic go on and ask the next question counsel and I would appreciate it if you have an objection state your objection but otherwise let me

conduct my questioning in the order that I wish to conduct it not in the order you think I should conduct it so just state your objection please.
MR. BARRON: I'm not trying to direct your inquiry nor impede it. I was trying to clarify it so it wasn't ambition I find the question now ambiguous maybe just leave it at that as being the objection.
MS. CHABER: Do you have the question in mind or do you need it read back?
A. It wouldn't hurt to read it back I have the first clause in my mind.
MS. CHABER: Read it back as is my unusual style I lose my train of thought with constant interruptions.
(Record read that was said with a smile.
(Record read)
MS. CHABER: Of small cell carcinomas.
A. No such data exist.
Q. Do you have any data with respect to the concordance or discord answer of autopsy and clinical diagnosis with respect to small cell carcinomas primary to the lung?
A. Yes. There are limited data on that subject. In the United States and the recently

published series by burden from what was formerly called charity hospital in knew Orleans now I think called the Louisiana medical center tumors of the respiratory tract were most frequently miss diagnosed of other sites examined. She doesn't give data specifically for small cell but similar but larger study was published from two medical centers in {PAOUD} da {PEFT} hungry {PR*EPB} and I believe there are data on cell type. They also found that lung cancer was frequently miss diagnosed and there are data in that study I think on cell type but I would have to look it up and quote it from the paper.
Q. Where is that paper published?
A. The first one I mentioned was published I think in the journal of the American medical association. I could be wrong. The second one was published in the journal called -- as I recall diagnostic and general pathology.
Q. Do you have a copy of that article with you?

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A. That would --
Q. The burden to know?
A. No.
Q. {PR*EPB} I do see some articles on top of

what appears to be -- let me just establish what it appears to be I'm correct I believe but what appears to be a binder of medical records that were provided to you doctor?
A. Well that's a duplicate of the record provided to me.
Q. In other words they had it appear and you didn't have to carry it on the plain?
A. Exactly I have that record at home.
Q. Okay. And then there's a second set entitled updated records when were you provided those?
A. On Wednesday of this week.
Q. Okay. Was that after you were here or was that while you were still at hope?
A. They were delivered to my home and the notes and data is indicated in the duplicate records that you have in your hand there.
Q. And speaking of which I would mark for the record and I believe we are up to four the remainder of the pages to plaintiff's Exhibit 1 which would consistent of the page of the doctors notes with the No. 1 marked at the top review of medical records October 29th 1998 the surgical pathology report from 2498 and the surgical report

from 2498. Go back to have the preyed cats done is this one article or more than one article that you have doctor?
A. I believe that's one article.
Q. And that's the sue Stern more ran article {PR*EPB}?
A. Yes ma'am.
Q. Are you familiar with the mount sign a medical center Miami school of medicine {PR*EPB}?
A. Yes indeed doctor ark Dee {TKPWREUF} land (A R K ADA Y R Y.
Q. A R K A D I according to this D I capital R Y W L I N?
A. In fact he was a fellow faculty member at the university of Miami on very -- I was very familiar with that department.
Q. Do you know {SAULZ} sister?
A. We've met I really haven't worked with him. Doctor {REUF} land {PR*EPB} died some years ago and since that time my contact with the medical center has been restricted some.
Q. Are you familiar with doctor -- excuse me, are you familiar with the department of pulmonary and mediastinal pathology at the armed forces institute of pathology?

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A. I wouldn't say I'm familiar with it I know of its existence.
Q. You know if it's a recognized institute of pathology?
A. The armed forces institute of pathology serves as a reference center for many departments of pathology throughout the country and indeed around the world.
Q. And do you know doctor moron or know of him?
A. I don't think so. We might have met. We might have discussed some cases but I don't really remember.
Q. And did you find or bring this article with you today?
A. I brought it with me on the airplane where I read it.
Q. Was it an article that was provided to you by counsel?
A. Yes. It was provided to me by counsel.
MS. CHABER: Take a quick break (11:05 4 a.m. 11:55 a.m.).
MS. CHABER: Doctor the first time that you read the article by sister moron on the airplane yesterday.

A. Yes.
Q. Were you told why that article was being provided to you?
A. Well, counselor, I was asked the question in a conversation with Mr. Pear if I had read this recently published paper. We were talking about the issues that had been discussed here this morning and I said no would you please send me a copy. He kindly provided it.
Q. Okay. At the time that you memorialized your opinion in writing as reflected in your notes is it true that you had not read that article by cyst {TEUR} and moron?
A. Yes.
Q. I did it again. Yes you had not a form that makes the answer confusing. What are the features of an anaplastic carcinoma that are consistent with thymic origin generally?
A. There are no microscopic features that distinguish anaplastic a small cell anaplastic carcinoma originating in anyone place from another place. They all look the same. They are all identical. So the diagnosis has made then on looking at the gross anatomical features in a given case and comparing organs to see which are most

likely to be the site of origin of a particular tumor in question and then to carefully address the question of probabilities before you make a final judgment call. It's a pretty standard procedure in addressing this particular problem.
Q. With respect to the case before you hear the henly case, do you have any differentials as to

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location of this small cell anaplastic carcinoma?
A. Well, we have considered that question already I believe major differential that you would have in approaching a case is whether it's a bronchogenic origin or not and if not then where and after you make that judgment about probably where was the alternative site of origin, are there other possible sites that have been overlooked so that you might be confronted with the problem of mediastinal lymph node ma cyst of small cell carcinoma originating at a different site. That's the differential.
Q. And is there any site more likely in the differential than another site?
MR. BARRON: Objection ambiguous.
THE WITNESS: Of the three general sites that we've talked about the findings in this case are most consistent with it having originated in the

thymus.
MS. CHABER: Are there any other body part sites that you would include in a differential diagnosis in this case?
A. Not in this case simply because the assessment of the patient including rather comprehensive radiographic studies CTs and the like don't point one elsewhere.
Q. What would you expect to find on autopsy if the primary site in this case was the thymus?
A. What would I expect to find at autopsy?
Q. Yes. This case.
A. Well at the present time following radio therapy and chemotherapy, it's hard to say. I would probably find regressed tumor pretty much destroyed by the treatment associated with an inflammatory reaction caused by the radiation treatment and chemotherapy. Had she not received treatment it would be very different but she did.
Q. Do you have a -- an opinion to a reasonable degree of medical certainty as to whether whatever disease Ms. Henly has is likely to result in her death?
A. I believe the program cyst is very poor an is likely to cause her death.

Q. And do you have any opinion to a reasonable degree of certainty what the progression of the disease to death would be based on the information that you have to date?
MR. BARRON: Vague and ambiguous big use as to the term quote progression closed quote.
MS. CHABER: Do you understand what I'm asking?
A. Yes I believe I understand the question and I would say that it would be very difficult to answer inasmuch as in my opinion this originated in the thymus and that the bronchus an organ where we are far more familiar with the evolution of the disease process, however, there are survival data on

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small cell anaplastic and other poorly differentiated carcinomas of the thymus that tend to suggest that the five-year survival rate for a small cell anaplastic carcinoma is very low because of spread to remote sites of the body. We don't know if it spreads in the same way as small cell anaplastic carcinoma of the bronchus however so we can't be specific about the organs that are most likely to be involved when because we don't have that much experience with these rare tumors.

Q. The rare tumor not being the small cell

bronchogenic carcinoma but rather being the thymic primary?

A. Yes ma'am nobody has collected a sufficiently large series of them to my knowledge to derive solid information about the exact sites of spread as the disease evolves we just don't know. But we do know that the prognosis is very poor in all the very poorly differentiated carcinomas of the thymus.

Q. Do you have an opinion as to what the length of survival in Ms. Henly you would expect based on everything you've reviewed?

A. It's my personal opinion that she's going to feel better than if she had a small cell carcinoma of bronchogenic origin and the basis for my statement is that persons with small cell carcinoma of bronchial origin quite frequently will develop metastasis to have abdominal lymph nodes in the adrenal glands to the brain to the bones to the liver and their outlook is very very poor. In her case the last CT studies that were done did not demonstrate any evidence of brain mass cyst her adrenal glands were normal. It was specifically discovered that unlike persons with bronchogenic small cells the lymph nodes around her pancreas were

not enlarged. In other words, remarkably she didn't show distant mat cyst at the last assessment the records of which I have I sincerely hope that continues. I feel that if she had mat cyst there as you see in a bronchogenic small cells her prognosis for even living months would be very poor.

Q. How long after radiation and chemotherapy of the type that Ms. Henly received would a small cell bronchogenic carcinoma ma to say size?

A. How long after?

Q. Yes.

A. Well I'm not an oncologist so I hope you will understand that I'm not quoting statistics from textbooks of oncology. I can only tell you that in my experience after successful treatment with radiation and chemotherapy that is to say when the patient goes into a remission and the tumor seems to did I say appear, on the average relapse occurs about a year or two-year and a half following such a remission and subsequent remissions are not as good and usually these patients are dead in less than two

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years.
MS. CHABER: Could I have the answer read back please.
(Record read)

MS. CHABER: In Ms. Hens case do you believe she's in complete remission?
A. No I have insufficient information to reach that conclusion.
Q. Do you have enough information to conclude whether she's in partial remission?
A. I think that she is doing quite well. You'd have to say that she seems to be doing well as of the time I read the record. I really can't say whether she's remission or partial remission. Those are terms that are best used by treating an oncologist.
Q. If we were to assume she was in say complete remission, how long has it been since she concluded her therapy?
A. Consulting the notes I made her radiation treatment seems to have been concluded in mid June of 1998. She continued with chemotherapy following that. I don't know if all of the chemotherapy has been concluded or not. That's all I have in my records.
Q. So at the earliest it's been approximately six months since the radiation correct?
A. Was concluded.

Q. Was concluded?
A. Yes ma'am.
Q. And you don't know how long it's been since the chemotherapy was concluded?
A. No tell you the truth I didn't review all of the aspects of her chemotherapy (to).
Q. Do you have an opinion, doctor, as to whether or not cigarette smoking is a cause of human disease?
MR. BARRON: Are we going to go through this again before lunch are we.
MS. CHABER: I guess so counsel.
THE WITNESS: I have not studied the relationship of cigarette smoking to every sees that has been related to it (disease) and the medical literature or the late press so I really can't answer that question in such broad general terms. I can say this: That it is my position in examining scientific evidence that it has not been established to my satisfaction scientifically that cigarette smoking causes any form of cancer of the lung but on the other handy want to make it clear that I think the statistical associations between cigarette smoking and {SKWAEUPLS} cell carcinoma of the lung and small cell anaplastic carcinoma of the lung are

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important epidemiologic data that suggests that the hypothesis that cigarette smoking may be a cause of those lung cancers is well worth continuing to explore.

Q. What do you require in order for you to conclude that cigarette smoking is a cause of small cell carcinoma of the lung?

A. The same thing that the first surgeon general doctor lieu they are Terry and later doctor see efficient order coop {PR*EPB} one of his successors surgeon general said they would like to have established scientifically the question of causation and those two areas are studies of {KARS} generosity of tobacco smoke with the development of experimental models that would {KHRAOUS} date the mechanisms of carcinogenesis and the secondary that they said they would like to bring forward in terms of evidence of an it logic association was the results of human pathology studies that further established a link between the smoking and cancer of the lung to complement the statistical studies which in and of themselves were not regarded as being {KPAEUBL} of establishing causation.

Q. Is it your testimony that doctor coupe while he was the surgeon general of the United

States did not conclude a causal relationship between cigarette smoking and lung cancer?

A. No ma'am that's not my suggestion whatever. In fact doctor coop and and the advisory committee to doctor Terry before him 1964 came to the conclusion that taking the three lines of evidence they presented together, there was sufficient reason for the surgeon general to be persuaded that there was a causal relationship between cigarette smoking and cancer of the lung. In my opinion they didn't live up to what they said they were going to do in the introduction and in the chapter on the criteria of judgment. They said in fact that the question of causation as used by them was based on a conviction derived from the data. Science is not an area where one's faith or conviction {STAOUTS} evidence but that's the position they took and stated in the monograph and I don't accept scientifically that approach. I really do need some confirmatory information of the type they said they would bring forward but in my opinion failed to do so adequately but that does not mean that I reject the importance of their work and it doesn't mean that I'm opposed to the main thrust of their recommendations as public offers citizens in

this country.

Q. Do you know any public health organization in the world that has not come to the conclusion that there is sufficient evidence to establish that cigarette smoking is a cause of lung cancer?

A. I don't know of any public health

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organization that has come to a different conclusion but doesn't mean is persuasive evidence of {STAOEUPB} {EUFBG} validity but it's important public health policy and I support these programs.

Q. Do you believe that cigarette smoking is a cause of emphysema?

A. In my personal opinion it's impossible to answer that question. Emphysema is a diagnosis that has to be made on anatomical grounds. Actually that's the position taken by a number of professional associations and pull {PHOLGSZ} on both sides of the Atlantic ocean. Yet the lung is not biopsied and persons who are said to have emphysema doctors simply say they have got emphysema. Well the accuracy of the diagnosis of emphysema and my personal experience based on follow up autopsies is about as good as flipping a coin and because of that I don't think that it's possible to look at the

statistical data and come to any conclusion because the population you are looking at is too poorly defined.

Q. Do you believe that there is any disease in human beings for which cigarette smoking is a cause?

A. Well I think cigarette smoking certainly is an person risk factor in a number of diseases. You and I might disagree on the question of causation but I think that perhaps we could all agree that cigarette smoking is an important element in the pathogenesis of the number of lung diseases.

Q. Do you know of any risk factor that is of equal magnitude to cigarette smoking with respect to lung cancer?

A. Not on the general population but of the answer nevertheless is yes. There are some it logic agencies that seem to be stronger risks than cigarette smoking.

Q. Such as?

A. Well for example the literature states that in persons with bilateral interstitial lung disease the risk of developing cancer is approximately 13 fold greater than the normal population. When controlled for cigarette smoking,

so in the population with that disease whether they are smokers or not, the risk factor is substantially high. There are also of course other important it logic agencies to which the general population may be exposed. You know, for example, in the state where I practiced Florida, there are substantial quantities of you Rainbow yum in the earth and the concentration of Raydon gas I know suppliersed breathed by people in some areas is substantially high and seems to make a significant contribution to the order {TPHAPBT}ly high incidence of cancer in certain regions of Florida. We can go on but we are talking about sub sets of the population usually occupational exposures to particular carcinogens and

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I think the thrust of your question was the general population rather than the small sub sets but there are a number of risk factors in the genesis of lung cancer.

Q. The subset with bilateral fibrosis?

A. Interstitial fibrosis.

Q. Interstitial fibrosis are those people with asbestosis?

A. No.

Q. What is the it logic agent of the individuals with bilateral interstitial fibrosis

that you are making reference to that have a 13 times risk of lung cancer what's the risk factor?

A. The risk factor is having interstitial fibrosis now if the question is what's the cause of interstitial fibrosis one can say that it's very diverse. One of the most frequent causes observed in the Midwest where I once practiced medicine is exposure to mold {AOE} hey. You may have heard of Farmers lung which is a condition of a rather serious nature that inflicts some Farmers who develop bilateral interstitial fibrosis of the lungs and they may die of pulmonary insufficiency or they may die of cancer complicating the interstitial fibrosis. Farmers lung is caused by exposure of Farmers to one or more {SPAOERBS} of micro organize {TPHAFPLZ} that we refer to as thermo fill I can {PR*EPB} ac continue know might seat he's A CT I N MO Y {PR*EPB} that organize {TPHAFPL} isn't unique to the farming profession or occupation. It's found in some buildings. It may be found in buildings that have contaminated air-conditioning systems or humidity control systems so in addition to Farmers office workers and postal workers sometimes reported to develop it on the basis of alga to that kind of organism. Secondly, exposure to animals. Most

notably parakeets or budge he's {PR*EPB} as they are called in Great Britain is associated with a risk of developing interstitial fibrosis of the lungs again on an allergic basis and by the same token {PAOEPBLG}ion breed ers will often develop this kind of problem.

Q. You are talking about micro back {TAOERPL} {AEUF} yum I want {TRA} sell lie {PR*EPB} {PR*EPB}?

A. I'm talking about exposure toant generals which are {PROET} teens derived from those sources that provoke an allergic reaction this is not an infection of the lung. However, since you have brought that up and we will say that there is some evidence in the literature that some cases of diffuse interstitial fibrosis of lungs may follow viral infections this has not been pinned down very well and we are not completely certain of that. There are other less known -- less well known areas that we could go into but I'm afraid it might take a long time.

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Q. What is the incidence of lung cancer in the United States that is due to the risk factor of interstitial fibrosis of the lung?
A. Well before I answering that I would like

to qualify my response. Cancer of the lung associated with diffuse interstitial fibrosis is one kind of star cancer (exited) the other kind of scar cancer has to do with particular scars in particular areas of the lung instead of affecting all parts of both lungs. Both these conditions are associated with an increased risk of lung cancer. The incidence of the cell types of carcinoma of the lung associated with scarring of either type is rising rather dramatically in this country and today in some large medical centers add know carpal knows and {PWROPB}al {HRAR} {KARS} {TPHOEPLZ} the cell types most commonly associated with this process account for up to 45 to 50 percent of lung cancers in the United States. There's been a marked increase in recent decades.
Q. What is the incidence of small cell bronchogenic carcinoma in individuals with fibrotic lungs?
A. It's small. I can't give you an exact figure but I would say definitely it's an uncommon cell type. It occurs but it's uncommon.
Q. Do you agree that lung small cell lung carcinoma is rarely found in an individual who was not a smoker?

A. Up to 85 perhaps 90 percent are smokers.
Q. What do you believe the risk factor to be in the other ten to 15 percent (moon exited) individuals with small cell lung cancer not smoking?
A. One has been rather conclusively demonstrated is exposure to a nickel compounds. Persons who work in the nickel processing industry have a high risk of developing small cell anaplastic carcinoma of the lung almost to the exclusion of other types. That's the only very strong association that comes to mind but we have to remember a very important point here and that is we can't always explain what causes lung cancer in a given case. There are a number of persons who seem never to have smoked who have not been exposed to nickel that developed small cell anaplastic carcinoma and we never find out what it was. They {STAOUT} perhaps largest fraction of those with small cell anaplastic who have no history of smoking.
Q. Let's take Ms. Henly assuming that her small cell carcinoma was indeed a bronchogenic carcinoma, what do you believe was the risk factors for that specific to Ms. Henly?
A. I have not reviewed specifically her

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smoking history, but I'm perfectly willing to except the propositions since I'm told that she was a smoker that if she were to have and I 'em {TPAOEUZ} were to have bronchogenic small cell carcinoma the most probable risk factor would be cigarette smoking.

Q. And if you were to assume she had approximate 100 pack year history of smoking over a 37 year time period and to assume further that she had a small cell lung cancer, you would agree that the most likely it logical cause of Ms. Henly's small cell lung carcinoma would be her cigarette smoking?

MR. BARRON: Objection to the phrase quote it logical cause closed quotas being ambiguous.

MS. CHABER: Go ahead.

A. Well the phrase is a little redundant.

Q. That's true.

A. I would say that that irrespective of how much she smoked assuming she smoked more than a pack of cigarettes a day as I said a moment ago I would accept the proposition that the most probable risk factor that could be possibly associated with her carcinoma cigarette smoking once one gets above two

packs a day it doesn't matter to me what the calculations are you are phrasing it a number of ways but you are still dealing with risk it doesn't make it anymore or less probable what you mean.

Q. (12 dole coal 30 p.m.) (12:57 p.m.)?

MS. CHABER: Doctor hensly, did you have any discussions with any other doctors involved in this case.

A. No.

Q. Were are you advised of what any other doctors involved in this case opinions were?

A. No.

Q. When was the first time you reviewed the pathology materials?

A. Let's see if I have it appear. Well it was sometime before October 29th 1998. It was probably on the preceding week or two.

Q. Do you have any kind of transmittal letters from anyone with respect to delivery of pathology x-rays medical records anything along those lines?

A. Medical records, yes, but x-rays have never been transmitted to me and the hiss tow logic {PRERPGZ} have always been brought to me in person but never mailed in relationship to tobacco cases.

Q. Do you know why that is?

A. No.

Q. Have you ever asked?

A. No I never asked.

Q. The first time that you looked at the pathology it had been personally brought to you by an attorney from shook hard and bacon?

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A. Referring to the present case, yes.
Q. Yes?
A. Yes.
Q. ; is that true in every case involving tobacco claimed disease that you've been involve with?
A. The microscopic {PRERPGSZ} have always been brought in person that's correct.
Q. And how many lawyers were present when you reviewed the pathology materials for the first time in the henly case?
A. I don't recollect.
Q. Do you recollect who was present?
A. Well I know that Mr. Pear was present but whether there was additional attorney with him or there was not is just not in my memory.
Q. And did -- do you have a did you believe viewed microscope that has more than one viewing?

A. Well, I do but I rarely use it. As a matter of fact, I just put on a duel view capability last week. I had taken it off when I retired and I just put it on last week.
Q. How many times have you reviewed the pathology in this case?
A. Twice.
Q. Was an attorney present?
A. I misspoke. I'm sorry. Three times.
Q. And the first time we just discussed Mr. Pear and possibly someone else brought the pathology to you for your review correct?
A. Yes.
Q. Did they review the pathology with you in other words?
A. No.
Q. Did you look at the pathology in their presence?
A. Yes.
Q. And did you tell them what you were seeing as you were reviewing it?
A. Yes. I usually do. I have no reason to suspect I did not in this case. But I'm not sure.
Q. Do you have any notes taken during that first review?

A. No, I didn't make any.
Q. Do you have any notes at all of any of your three reviews of the pathology materials?
A. Only what I've given you.
Q. And --
A. Actually, let me say that if I may the notes that you were presented with this morning I brought from my home where I had them in this file for knee Monday I can M N EM O N I C purposes.
Q. Meaning?
A. To jog my memory. These files had never been seen by anybody except myself that is to say they don't {STAOUT} a report or had never been -- I don't think anybody even though they existed until

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this morning except for myself.
Q. Did you have a discussion at any time since this morning with counsel about those notes that have been provided to me today?
A. We have not discussed the contents of these notes.
Q. I don't mean the contents. I mean the existence of them or any of the comments or complaints that I had at the beginning of this deposition?
A. It was brought to my attention by counsel

here that he was unaware that these notes existed and I said, well, here they are. These are the notes.
Q. Is it your regular practice, doctor, to make notes when you review a case such as this?
A. It depends on the case. If there are lots of slides, they are very complex nature, I may make notes as I'm actually working at the microscope from slide to slide. In a case like this one where there's only one relevant biopsy and a cytology or two I just simply record information the way you have seen this morning and I don't make any specific descriptive notes. I didn't in this case.
Q. Is it your regular practice in the medical-legal case such as this to make notes whether it is of pathology your review of x-rays or your analysis of medical records?
A. Well I don't have a consistent policy. It depends entirely on the case. If somebody sends me slides and an autopsy record for example, I'm not talking about tobacco related cases now but other cases and once an opinion what I do is pick up the telephone and call him and say well I've just finished reviewing the case. I give him my diagnosis and ask him what they would like to know

or discuss and I do it. On the other hand if it's a very complicated case that requires a lot of detailed analysis, then I will make notes that I will consult when I talk later on the telephone with the attorneys.
Q. Now you distinguished medical-legal cases from the tobacco cases do you have a different practice as it relates to tobacco cases?
A. The reason for my distinction is simply this: That when I'm consulted but folks in medical malpractice cases as I am from time to time, they usually mail me the slides and they are not there to talk with face to face at the moment I finish the case. So I distinguish that because with the tobacco cases the attorneys personally bring to me the slides and they are present with me so I can conclude my work turnaround give my opinion and that's that.
Q. In this case on this first occasion when Mr. Pear and possibly someone else though you don't recall came with the pathology materials, did they

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have any other materials with them related to Ms. Hen?
A. Not that I recall. I think the medical records were sent to me later.

Q. Did you form an opinion with respect to this being a anaplastic carcinoma more consistent with a primary thymic cancer on that first occasion when you reviewed the pathology?
A. No. The opinion that I had and communicated was the following: And the pathologic materials were consistent with a small cell anaplastic carcinoma. They did not in and of themselves point to the site of origin.
Q. Was it indicated to you at any time in that first meeting or prior to the time that you received any medical records that there was a question as to whether this was a lung primary or a thymic primary?
A. No. That question was never raised.
Q. At what point in time did you conclude that the small cell carcinoma that you had seen through the microscope was more consistent with thymic origin than lung origin?
A. Well, it was on or around November third this year after having initially reviewed the medical records to review in this office in San Francisco the x-rays of the chest CT. My opinion based on the totality of material at that point was that this was an anaplastic carcinoma with features

consistent with thymic origin on the basis of the clinical pathologic correlation which is to say not based strictly on the biopsy but the totality of the case.
Q. Was it your opinion on that occasion on November third or by that occasion on November third when you wrote what you just read (moon still gone) under the date of November third 1998 that the anaplastic carcinoma that you had seen in the microscope had features more consistent with thymic origin than lung cancer origin?
A. Well, I didn't say that but that doesn't mean I meant it.
Q. I'm asking at that time did you mean that, sir?
A. Not precisely, no. What I meant is verbatim what I said that the features were consistent with thymic origin. I will add that I thought at that point that it was more probably a time I can origin than of bronchial origin in fact I have formed an opinion based on examination of the medical records the chest x-rays and the C {T*PBZ} that this was possibly not bronchial origin. So I felt on November third that this was consistent with the thymic origin but I it not take the position

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dogmatically that it could not have occurred elsewhere and secondarily spread to the mediastinum.

Q. Were there any features of Ms. Henly's -- I just -- strike that for a minute. I just want to clarify. When you say anaplastic carcinoma in this case are we talking about a small cell lung -- a small cell cancer?

A. Yes ma'am I'm sorry I misspoke myself.

Q. If I use the terminology small cell carcinoma as opposed to your anaplastic carcinoma which is written on the November third notes, we will agree it's synonymous?

A. Right.

Q. All right. Are there any features of Ms. Henly's small cell carcinoma that are consistent with a bronchogenic primary?

A. Based on his microscopic appearance, no.

Q. Well, because as I've stated earlier this morning, the microscopic features of small cell anaplastic carcinoma are identical no matter what organ they are originally from if you are looking at a piece of tissue under the microscope, you can never underlying word never, you can never say that it's hiss {TOPBLG} I can features suggest it rows to the bronchus the thymus the stomach or any other

specific site that's totally impossible.

Q. Were you finished with your answer?

A. Yes.

Q. Okay. I don't think my question then was very clear because I think you answered a different question and certainly I I know Tedded. The totality of materials that you have do you believe that there are any features in Ms. Henly's small cell carcinoma that are consistent with a lung primary of small cell carcinoma with a lung primary?

A. Thank you for restating that. I understand perfectly your question now. And my answer is, no there is nothing consistent in this case with it representing bronchogenic primary and that is it was of cardinal importance to me. I would like to say that the sputum cytology was negative when the chron could say scope was done the person who did it and explored that region of the {PWROPB}ial tree found no evidence of a tumor. The CT of the chest is very atypical for a presentation of a small cell anaplastic carcinoma with mat cyst to regional lymph nodes inasmuch as it was seen that the mass was a single mass not a group of lymph nodes that were separate and {STKREUPBGT} from one another or even fused together. It was a single six

centimeter mass that's about two and a half inches or slightly less situated in the anterior and middle mediastinum with lobular features. This would be very exceptional for a small cell anaplastic carcinoma that normally if you have any one Massachusetts static to the lymph nodes and chest it's going to have several others in addition.

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Taking all of those things together and the follow up studies that I mentioned and CT of the abdomen and pelvis not showing any other possible site, it just seems -- of mass cyst that you would expect from a small cell carcinoma of bronchogenic origin it just seems to me there's nothing to support the diagnosis of bronchogenic origin of this small cell cancer.

Q. Do you know in all the reported literature to date how many thymic carcinomas have been identified?

A. I've never made an effort to ascertain that.

Q. Do you know if the number is under 100?

A. I don't know the international statistics. I don't know how many have been reported in Europe or America or elsewhere. I have not made an effort to find out how many thymic

{KARS} openly {PHAZ} {SRFB} reported in the world literature.

Q. Would you be surprised if it were to turnout that there were 100 thymic carcinomas reported in the literature?

A. Well, I wouldn't be particularly astonished but I would be surprised that I had seen as many as I had in my own personal experience and I would suspect that the registries compiling the data have access to only a small fraction of the total possible thymic cancers in the world, for example, if you were to write the registry of the armed forces institute of pathology asking for their numbers, you would not find those that I have seen at Jackson memo {KWRORL} hospital because of instead of sending the material to the A F I P I shared the material and consulted another expert ron row sigh {PR*EPB} so you would have to take into account that numbers that you are putting out are certainly minimal at best estimates because not all cases are reported to the agencies that publish the data.

Q. Don't you think sir it would be of important medical information to provide the information on the thymic carcinomas that you yourself have seen if you feel that they are not

counted in the worlds report of thymic carcinomas?

A. Would you repeat the first phrase.

(Record read)

THE WITNESS: Thank you of course it would be as I indicated when I run across unusual lesions of that type, I usually consult experts in the field to share my professional experience with them. I don't feel it's incumbent upon me as a person who sees only a few examples of rare disease myself to publish the data and the literature. I have shared that with experts that more frequently are right on the subject and make use of that material in their own work in their own subsequent publications and I feel that that meets my duty. I

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certainly do not need to report it to the A F I P the armed forces institute of pathology and I don't need necessarily to report it to any other agency that collects statistics. There are lots of them and I couldn't get around to them all I just don't feel it's my responsibility (could).
Q. With respect to the thymic carcinomas that you have identified who have you consulted with?
A. Well, three people that come to mind three that come to mind I want to emphasize are

doctor ron row say who is recognized as an authority on the subject and has written a number of papers, doctor Benjamin cast he will man {PR*EPB} who was at Harvard university and hospitals in Boston. He is now deceased. It seems to me I have also shown cases to doctor he will bore {RA} is a {SRAEUT} A L B O R E S hyphen S E V did you believe A R T A. I'm sure I've shown him slides and discussed cases. I don't know if he has done anything with them. Incidentally he of course is affiliated with the armed forces institute of pathology.
Q. Can you give me his name again?
A. Lapse is a {SRAEUT}.
Q. The last name --
A. This is one name.
Q. {HRARBS} {HAOEUFP} what's the second part?
A. S E V did you believe A D R A. You know whether he's done anything with those cases in terms of reporting them to the other sections at the A F I P I don't know.
Q. You don't know whether those cases are actually included in the paper where one of the authors is from the armed forces institute of pathology do you?

A. I don't think it would be because I didn't specifically report them to the A F I P. I have never reported cases to the A F I P of any disease process.
Q. I'm talking about the thymic carcinomas that you identified that you discussed with doctoral {PWORS} {SAFL} da?
A. {SAFL} dough.
Q. {TKAF} so he?
A. That's the way he pronounces it.
Q. Okay. {TKAF} dough you don't know whether those same time I can carcinomas are included within the ones discussed in the {SUS} ter more ran paper do you?
A. They are not to the best of my knowledge they could be but not to the best of my knowledge.
Q. Do you agree with the very first statement made in the {SUS} ter more ran paper that primary thymic carcinomas are unusual neoplasms?
A. Indeed I do.
Q. And have you culled or written doctor

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{SUS} ter and moron to let them know that you have seen ten cases of primary thymic carcinoma?
A. You are misquoting me. I never said that I saw specifically ten. I'm sure if you go back in

my record the number is going to fluctuate around that number. I didn't say ten.
Q. Approximately ten?
A. Well approximately, yeah. But no. There's no reason in the world that I would take it into my head to mention it to these two gentlemen, no. That is not the way medicine is generally practiced in America today.
Q. Have you written a letter to the journal of pathology to advise them that indeed you have seen approximately ten thymic carcinomas that have not been included in the medical literature?
A. That would go directly to the waste basket it would be a silly communication. Editors don't work that way. Doctors don't work that way. There are some journals like the New England journal where people write little letters and the pathology literature generally and other specialists we just don't work that way. It would never occur to me to do that and I think any editor that got such a letter from me would probably to say it in the waste basket.
Q. Do you agree with the statement that small cell carcinoma of the lung is known to metastasize mass I feel to the {PHAOEZ} {STAOEUPB}

you mean at a very early stage when the primary is not detectable by radiographic means?
A. To mediastinal lymph nodes, yes that's an important qualification here.
Q. So then when the authors say metastasize mass I feel to the mediastinum, you would qualify that statement; is that correct?
A. Yes sorry.
MR. BARRON: We are going to get a confused record here. I didn't mean to catch you in mid answer but I did want to get my objection in. It's ambiguous the way you phrased the question are you asking for his personal opinion as to when it appears mass I feel how does it appear or are you asking him to try to interpret the minds of the authors or just what.
MS. CHABER: The authors of this article, doctor, have stated that small cell carcinoma of the lung is known to metastasize mass I feel to the mediastinum at a very early stage when the primary is not detectable by radiographic means and I am asking you if you agree with that statement.
A. Not as stated.
Q. Let me finish as stated and you just indicated you don't agree with it as stated you

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would qualify it am I correct by substituting for mediastinum mediastinal nodes correct?
A. Mediastinal nodes or structures. I hate to be picky but mediastinum is a space, not a thing and the involvement of structures in the mediastinum occurs but not at the mediastinum itself.
Q. Do you agree with their statement that the rendering of a diagnosis of primary small cell carcinoma of the thymus must be based on the exclusion of the primary tumor elsewhere?
A. I absolutely agree with that and I would say by the very same token that criterion also must be implied to biopsies obtained from the bronchus the small cell cancer before a pathologist can make the statement that the small cell cancer obtained through a {PWROPB} scopic biopsy has originated in the lung he has to see the site of origin so the same principal applies not only to the thymus but to the bronchus and other sites as well.
Q. Do you agree that a primary small cell lung carcinoma can exist at a stage when the primary is not detectable by radiographic means?
A. Of course.
Q. And do you agree that there can be small or O cult lung primaries in the presence of bulky

mediastinal disease?
A. Yes.
Q. And I am correct that prior to the time that counsel gave you this article but subsequent to your conclusion that Ms. Hen {HREUZ} case was more likely a primary thymic carcinoma than a lung carcinoma you had not read this article by doctor {SUS} ter and moron?
A. That is correct.
Q. And doctor, did you read any articles in preparation for this case relating to thymic cancers?
A. Not articles per se. I did consult a reference.
Q. What reference did you consult?
A. The reference that I consulted was A C K ER M A N's textbook of surgical pathology Byron row sigh. The 8th edition published I think in 1996.
Q. Has doctor row {STKAOEU} published any articles as opposed to this text with respect to thymic carcinomas?
A. Indeed he has. He is sort of a father of the concept of thymic carcinoma and you will find citations of those articles in the paper before you.
Q. In the {SUS} ter?

A. Sure.
Q. Okay.
A. I'm sure that's true. If it's not, there's something wrong.
Q. Have you read any of those articles by row sigh?
A. I don't remember all the articles I read.

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I probably have some years ago but I don't really remember specifically I've talked with doctor row sigh on these subjects.

Q. You talked with him about Ms. Hen {HREUZ} case?

A. Certainly not about Ms. Men {HREUZ} case about the subject of thymic disease.

Q. Am I correct that this is the first case of small cell thymic carcinoma that you have seen?

A. Yes.

Q. Do you know how many cases of small cell thymic carcinoma the doctor rows eye has seen?

A. I don't think that he's published that information but I could be wrong.

Q. Do you know how many cases of thymic carcinoma that doctor rows eye has seen in total irrespective of cell type?

A. I have never made an effort to find out

and remember how many cases of any disease doctor rows eye has seen.

Q. Are you familiar with doctor Sammual ham ar?

A. No only that he's the author of the textbook pulmonary and pathology I believe and also I'm told that he has been retained as an expert witness in this case but I'm not familiar with doctor ham ar's work.

Q. You do not have either of the volumes of doctor ham ar's book?

A. No.

Q. And you've never read any articles authored by doctor ham ar?

A. Well I won't say I've never read any articles.

Q. That you can recall?

A. That I can recall.

Q. Who else have you if any have you been told has been retained as experts in this case?

A. The name of a radiologist came up yesterday.

Q. And do you know who that radiologist was or what the name was?

A. It's from Miami Florida fine stone or

fine {STAOEUPB} probably {PR*EPB} that's the only name that I can associate with this case in terms of professional witnesses.

Q. And what were you told about that radiologist from Miami?

A. Well, I was told that he had examined the CT films that I had looked at.

Q. And?

A. And --

Q. What else were you told?

A. Well, I think he agreed that the lesion was anterior and middle mediastinal, that in the center of the anterior mediastinum at the level of one cut he interpreted a shadow as consistent with

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the position of the thymus gland of the patient.
Q. And did you anything else?
A. That's all I recall.
Q. And did you review that cut {FRPLT} I looked at it and I looked at the cuts above and below?
Q. And what did you determine?
A. Well, I didn't determine whether the radiologist was right or wrong. I don't consider myself qualified to dispute the interpretation. However, I pointed out that it's not a very

pertinent organization one way or the other because when thymic {KARS} memo {PHAZ} originate within land, they don't do it everywhere all at once. They originate in a particular location and gradually expand to adjacent tissues. So whether that structure on the anterior mediastinum represented a residual portion of an involute thymus in the middle age lady or not didn't strike me as very important.
Q. Did you conclude that that was not what was identified in that cut -- was not a residual thymus?
A. No. As I have said it was in a position where it might have been. It's not a very important point. There's a lot of variation in the location and extent of the human thymus and to imagine that, it's confined to the anterior mediastinum as to indicate to me that you haven't done very many autopsies on human beings to discover that the thymus often extends posteriorly around the heart and back toward the bronchi so as I said for that reason I couldn't get very excited about the observation in a positive or negative way. It just wasn't very determining of anything.
Q. Are you familiar with the American journal of surgical pathology?

A. Yes.
Q. Is that a journal that you read?
A. Occasionally. I don't take it at the present time.
Q. Have you read any articles on thymic carcinoma published in the American journal of surgical pathology?
A. Not that I recall offhand.
Q. Can you tell me symptom logically what is the typical presentation of a small cell thymic carcinoma?
A. No. That's a bit of information that I would simply never to try to find out or to remember. That's the kind of information that's much more important to a clinical physician than to a pathologist and I just simply don't have any idea what the presenting complaints are.
Q. Do you know how many small cell primary thymic carcinomas have occurred in the anterior mediastinum?
A. Well as I've said before counselor, I

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don't know from the literature how many small cell carcinomas have been reported anywhere let alone in the particular come part amendments of the mediastinum. I can tell you that all compartments

of the mediastinum have been reported to be the sites of malignant {THAOEUPL} memo a with a possible exception of the posterior mediastinum but further than that I would not go because I just don't have the specific information.

Q. And if authors who did have the specific information or to conclude that all reported cases of thymic carcinoma of the small cell variety were located in this superior mediastinum, would you have any basis to disagree with that?

MR. BARRON: Objection argumentative as form.

THE WITNESS: Well I wouldn't disagree. I would respectfully suggest that it's rather unimportant and meaningless piece of data inasmuch as the total number of cases reported anywhere is very small so it would be in my opinion premature to attach significance to statistical reports in 1998 but secondly, there's no A priority reason to take the position that any one portion of the thymus gland is more predisposed to the development of cancer than any other inasmuch as malignant tumors to the thymus have been reported in all sections of the mediastinum {SREPT} for the piece torior. I just couldn't except that as a very meaningful

communication at this time (accept).

Q. When photocopies are made they often do not photocopy yellow highlighting and I notice --

A. I would be happy to trade you.

Q. I notice that your notes and the copies that your notes had some highlighting. On the surgical report which I believe is the last page of your attached to your notes; is that correct?

A. Yes ma'am.

Q. First of all, is that your highlighting?

A. Yes I made those marks.

Q. Could you just read into the record the portion that you highlighted?

A. Well there are two. The first occurs in the paragraph labeled indications for procedure and I have highlighted the last sentence which reads as follows: The sputum cytology was negative and it was felt this lesion would be best approached by anterior immediate {STEPB} scope.

Q. I'm going to stop you there. What's the reason you highlighted that?

A. I didn't fully understand this to me is a peculiar -- excuse me, this to me is a somewhat unusual statement not peculiar I want to retract that. The sputum cytology being negative, well,

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sputum cytologies are not very good for lung cancers but if they are good for anything they are good for centrally lung cancers as shown by many studies. This ladies putative lung cancer was centrally located. So I think that --

Q. Could I stop you there?

A. Yes.

Q. There was only one sputum cytology done correct?

A. I know that's another very important point. I felt that that being the case that they had only one sputum cytology and it was negative, it was unusual that the operator would not endeavor to get cytologic materials from the bronchus. Normally what one does when working for a patient like this and putting in a {PWROFRPBG} scope is to look for an occult carcinoma such as you have described earlier one you can't really see well because it's so well. What you do is look very carefully for any abnormality and then you brush that lesion with a brush to get cells from it to see if you can determine if it's cancer. In addition to that, usually you inject some fluid into the bronchus and wash it back and forth and aspirate it and you submit cytology specimens to the department of

pathology so they have what we call bronchial washingings and bronchial brushings to establish whether a tumor is present in the bronchus or it isn't. For some reason I do not understand it was he elected not to do that.

Q. Let me stop you there were you about to go onto the next part of the sentence?

A. No.

Q. Go ahead then?

A. The second part of the sentence that {TRUBLDZ} me.

Q. I wanted to stop you there on the sputum {SAOEUL} {TOLG} when you are done with your remarks with respect to the sputum cytology and the unusual nest of the surgeon not having done washings or brushings?

A. Yes I'm finished with that part of that sentence.

Q. Now I want to ask you some follow up questions on that before we go onto the next one. Do you believe that the surgeons failure to do bronchial washings or brushings falls below the standard of care for a surgeons in trying to determine the diagnosis of a potential cancer?

MR. BARRON: Objection I think it's not

relevant for discovery purposes but he obviously is able to answer it if he wishes.

THE WITNESS: My answer is that not necessarily. {*EUF} a very high regard for the medical center where this work was done. I don't know in detail of the procedures that they are currently using (all) and I don't know whether this

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is a deviation from their usual standards or not so I certainly would not sit here in judgment of the person who did this procedure. I'm simply saying that my experience is unusual and it's very you know fortunate in this case because there was a possibility that the cytology could establish where the tumor originated and that possibility was bypassed. That brings me to the second clause of the sentence.

Q. Do you know either doctor mason or doctor {HAEUG} even {PR*EPB}?

A. No I never met him.

Q. And you said you have high regard for this medical center. What is that based on?

A. Well, the Los Angeles county U.S. C medical center enjoys very good national reputation as a center for providing patient care and particularly in the area of pathology they have long

and distinguished record of contributions to the medical literature. There are many fine people there. I think most everybody would agree especially with regards to pathology that it's an outstanding department.

Q. And do you -- were you aware that Ms. Henly was an indigent patient?

A. No but that to me would be completely irrelevant as much as I've worked in similar medical centers and I can assure you that it doesn't matter whether the patients I've been responsible for diagnosing are indigent or not. They get the same standard of care.

Q. And that was going to be my question to you was whether or not you believe that had anything to do with their failure to have done washings or brushings?

A. I once observed this happen to a senator.

Q. He didn't have a thymic carcinoma did he?

A. It turned out he had a bronchogenic carcinoma small cell anaplastic type.

MR. BARRON: See how one answer gets you more questions.

MS. CHABER: Second part of that sentence.

A. Bear in mind that I just said by bypassing the cytology you are giving up the possibility of establishing where this tumor truly originated. You've given up that card. In the second clause it was felt this lesion would be best reached by anterior immediate {STEPB} scope okay perfectly true but bear in mind that once you've made that decision you've given up the chance of determining again from where the tumor occurred because it wouldn't matter whether it was bronchogenic or if it originated elsewhere if you are getting it out of the mediastinal lymph node presumably you've just surrendered that chance. There's no way you could do it.

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Q. Because that's a place of mat cyst from mediastinal node is is a place of mat cyst from small cell bronchogenic carcinoma correct?
A. Or the other site.
Q. That's why you were suggesting that by he electing for an anterior immediate scope again the doctors there were bypassing an opportunity to determine the site of origin; is that correct?
A. Yes ma'am. You see it's recommended by many people that if you are confronted with this problem and you want to make a diagnosis that A you

do the cytology studies I mentioned and B you even do blind needle biopsies of the to see if there's cancer present there. I can understand the surgeon saying well the best evidence of cancer is going to be in the mediastinum so I will go through to get that but that doesn't tell him from where it came.
MR. BARRON: I think you were -- I'm being fairly lenient here you were talking about something important to you I'm not sure it was matching the question totally now what we do need is another question or we are going to have a transcript difficult to follow.
MS. CHABER: It was matching the question.
Q. You indicated sir that that puzzled you as to why that was done; is that correct?
A. Yes I found it to be a bit unusual and I thought it was worth highlighting.
Q. You believe that doing that was beneath the standard of care or in the medical community?
A. I've already answered that question.
Q. We talked about it with respect to some other things that I was following up on the second part of that. Is that the only what you've described already are those the only reasons that

you highlighted that second part of the sentence it was felt this lesion would be best reached by anterior immediate scope?
A. Well there's one other point that couldn't have been in the surgeons mind but in my mind after having looked at the biopsy.
Q. And that is?
A. Its sort of implied in that statement but I highlighted that the surgeon was going to biopsy what he felt was mediastinal lymph nodes that might be the site of meet cyst small cell anaplastic carcinoma but he didn't do that. He may or may not have known that he did or didn't do it but we really came out of this ladies chest with was a piece of adipose connective tissue and not a lymph node. The fact that it was a piece of fat tissue or adipose connective tissue is of some importance in retrospect it was not important at the time to the surgeon but the reason it's important is that small cell anaplastic {KARS} memo {PHAZ} of bronchial origin usually metastasize to the regional lymph

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nodes and that's why they get enlarged. They do not generally infiltrate the fat of the mediastinum in a diffuse fashion. That would be somewhat atypical but that's exactly what he came out with based on

histology of the biopsy is a good deal of the tissue was simply just fat tissue. So subsequently that becomes some importance in trying to decide the issue where did the tumor come from. And the immediate {SKOP} isn't the best way to establish that point. It's limited and it was for that reason I included the second clause of my highlight.

Q. In the description of the procedure in detail you also highlighted some lines, correct?

A. Yes.

Q. Let's try if we can for you to break them down even if they are not at the end of a sentence but rather at the end of a portion of a sentence that you thought significant such as we did in the one beforehand where there was a compound sentence and there were two parts and we stopped to talk about each part can you do that?

MR. BARRON: And he will. May I just interrupt for a second and talk about scheduling in light of him wanting to hook up with his daughter.

THE WITNESS: Yes.

MR. BARRON: And the bookstore let's just go off the record for a moment (off the record).

(1: 56 p.m. (156 p.m.).

MR. BARRON: Would you've got the

question.

THE WITNESS: A section of the airways showed she had a mild inflammation of her left upper lobe bronchus; however no obvious endobronchial lesions were seen the rest of the bronchial tube also revealed no abnormal lesions the obvious reason that I underlined that or rather accented that is that the operator found no evidence that this lady had bronchial cancer and I thought that was an important thing to highlight.

MS. CHABER: What do you attribute the mild I know Florida Asian of the left upper lobe bronchus to be?

A. That's practically pardon for living practically everybody has a little mild chronic bronchitis based on endoscopic or pathologic criteria and it has no distinctive meaning.

Q. Anything else highlighted?

A. No ma'am.

Q. Any other reasons you highlighted that?

A. No.

Q. You had in your notes now your handwritten notes that are the first four pages you had some highlighting on the --

A. Would you like me to indicate what they

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are.
Q. Yeah.
A. First the document dated 1214 I have --
Q. Let's make sure we are on the same paining what does it say at the top?
A. Henly records send by July a {WEURD} on December 14th.
Q. Who is July I can't {WARLD}?
A. I know she's the secretary I believe at this firm. The first highlighting is dated 3198 it's the date of an examination namely her CT of the lung which I've just indicated is a left hilar mass possibly sill centimeters on chest x-ray.
Q. What was the reason you highlighted that?
A. Well, they reported a single six {SAOEPBT} meter mass that's about something slightly less than two and a half inches only one mass. It really raises a question what is it. The two things that would come to my mind would be -- well, really malignant limb foam ma and kind of down the list would be met {STAS} I can carcinoma involve in the nodes. Usually the met {STAS}tic carcinomas especially if they are of small cell anaplastic type do not obtain a dime {TAOERT} of six centimeters and yet be contained to a single node when you say a

node that large related to small cell anaplastic carcinoma of bronchial origin generally speaking you see several nodes at least in the same region and that feature is very unusual in my experience for bronchogenic carcinoma of a small cell anaplastic type.
Q. You are saying that on the x-ray and the CT scan you can actually see nodes?
A. Yes. You can when they are the site of disease, yes. That's exactly what one sees as what you described as massive mediastinal growth it's enlarged lymph nodes it's not diffuse infiltration into the mediastinum. Let me remind you that the structures for this massive infiltration it was in the mediastinum include the pulmonary artery the heart itself and the art at that if there were diffuse infiltration outside the lymph nodes a patient would be dead and on the autopsy table. The fact is what you say are the lymph nodes at the site of disease and they confine growth of tumor for a while.
Q. This is not a lymphoma though correct?
A. No but malignant lymphoma can produce the same appearance that's why it's always in the differential diagnosis.

Q. But you've ruled out that diagnosis that is limb foam ma?
A. Yes. The second highlighting is part of that same date and it says no add pop think elsewhere in the chest that's referring to the CT study that's saying today and that just reiterates what I just said they only found a single mass.

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They did not find enlarged lymph nodes which would be very unusual for small cell bronchogenic carcinoma. The third thing highlighted on that page is eleven October 98 it says follow up chest CT no definite mass seen MRI brain and skull negative CT of abdomen negative pelvis okay, too. That indicates as I said this morning that it looks like the chest disease has responded pretty well to treatment and the sites of mass cyst that we usually associate with small cell anaplastic carcinoma bronchial origin are not involved by tumor as far as we can tell as of October eleven, 1998.

Q. Which is I think we talked about a few months after the conclusion of radiation taper and you don't know how long after the conclusion with chemotherapy correct?

A. Yes ma'am that is correct and that's the extent of it.

Q. Now, you were disclosed with respect to opinions on a number of other topics including autopsies and death certificates do you have opinions relating to the henly case with respect to autopsies?

A. Well naturally I have opinions in these areas because I've worked in that for a long time. I would be happy to answer any questions if you think that they are relevant with respect to the henly case I can't think of any specific comments derived from those areas that I would like to bring up at this moment.

Q. How about with respect to death certificates specific to the henly case?

A. No ma'am I don't see any relationship.

Q. We've already talked about pathology in relation to the henly case and your opinions that would be relevant to that?

A. Yes I don't have anymore to add I think other than just to briefly to the I am hiss tow chemical studies that were done as a follow up to the biopsy at UCLA.

Q. What did you mean by allude those?

A. One thing I did highlight perhaps this is not very important is that they made the comment

that the keratin was positive.

Q. You are referring to the surgical pathology report I don't mean to interrupt you?

A. Yes the surgical pathology report you know I might want to mention that I agree with the diagnosis established here small cell carcinoma of the left hilar lesion. I want to point out that the pathologist did not say what the site of origin was. That was left open. In his comment he says that the care continue was positive and was negative for R D 45 and chromogranin would support the diagnosis. This is just slightly confusing. I agree that the positive care continue tends to support the diagnosis but I would say that -- and I {TKPWRAO}

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that it's important that the C D 45 is negative because that helps rule out limb foam ma but the negative chromogranin does not necessarily support the diagnosis as much as it may be positive or negative in any small cell anaplastic tumor of any site of origin. So I want to make it clear that those hiss tow chemical tests do not necessarily support any interpretation that this is of bronchogenic origin but other than that I have no further comment on pathology.

Q. What would you expect the

immunohistochemical studies to be if this were a small cell carcinoma of bronchogenic {ORPBG} I know?

A. The point is it doesn't support diagnosis of any one origin because they are all the same.

Q. It's not supportive of it being thymic primary either?

A. Oh, no indeed not.

Q. Are there any studies that could be done D N A or otherwise --

A. Not that are presently accepted as useful.

Q. I believe that electron microscopy would establish any (do you believe) site of origin over the other small cell?

A. No I am certain that it would not be of value.

Q. Do you believe that lieu seven would provide any information L E U -- seven?

A. No that and another study that was actually done but not reported at UCLA {SEUPBT} {TPAOEUS} I know may be positive or negative in any small cell anaplastic carcinoma.

Q. So {SEUPBT} {TPAOEUZ} I know as a diagnostic tool for the differential of small cell lung cancer versus thymic cancer wouldn't change

your opinion whether it was negative or positive?

A. That's correct. I'm speaking as a person who specializes in the pathologic diagnosis of diseases of patients and I want to say that those tests may be positive or negative depending upon the extent of newer secretary Terry {PR*EPB} differentiation seen in a specific example of small cell but whether small cell carcinoma showed newer {SEBG} Terry different {SHAEUGS} or don't show it their biological behavior is defined in terms of their appearance by light microscopy using conventionally stained slides that's important to bear in mind so we don't get off on a tank he went about the heist chemistry and electron microscope of their relatives which are more highly differentiated tumors.

Q. And do you believe that P 53 would have any value in differential diagnosis in this case between --

A. No.

Q. Sites?

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A. No P 53 would not be of use.
Q. And that would be true of chromogranin A as well?
A. Yes all of those methods directed at the

demonstration of so-called newer second Terry {TKPWRAPB} use or newer row and specific differentiation are of no proven value in that variant of these tumors that we call small cell anaplastic carcinoma.
Q. Is there a test for the presence of thymic hormone in small cell carcinoma?
A. I don't know.
Q. In thymic small cell carcinoma?
A. I don't know but I want to reiterate what I said before that most authorities would agree with the statement of rows eye that all of these additional tests whether of demonstration of hormones or newer secretary Terry differentiation has no baring on the question of whether the tumor should be classified as small cell anaplastic carcinoma or not because that is the case and because there isn't any great revolution in our thinking about it in recent years, nobody tries to use all of the various tests can be employed because they don't really seem to make much difference.
MR. BARRON: You are a professor and you have a tendency to educate which is okay if you have any desire to get to your daughter by three o'clock you ought to limit your question rather than

expanding.
THE WITNESS: You are hundred percent right.
MS. CHABER: We are doing very well and it almost makes it easier with the way you've been answering but counsel can instruct you however he wants you.
Q. Do you believe that a positive thymic hormone would establish this cancer to be of thymic origin?
A. No definitely not.
Q. It would rule out this cancer in Ms. Henly of being of bronchogenic origin?
A. No, I did not.
Q. (did you) can you tell me what percentage of carcinomas diagnosed as primary lung tumors turned out at autopsy to be of thymic origin and not lung tumor?
A. No.
Q. And do you know the opposite question how many thymic carcinomas diagnosed in lifetime turned out to be bronchogenic primaries?
MR. BARRON: Can I have that reread please.
(Record read)

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MS. CHABER: Let me add at autopsy I think it was implicit in the question but I'll clarify.

A. While I've seen the first situation occur I've never seen the last. It must be very very rare if it ever occurs.

Q. Do you know how many of the thymic carcinomas of the small cell variety reported in the medical literature were diagnosed upon autopsy and not at clinical diagnosis?

A. No.

Q. Couple minutes to look at my notes and be able to get you out to see your daughter. (off the record)?

Q. Do you know how many surgeon general reports there have been on the health consequences of smoking?

A. No.

Q. Have you read any of the surgeon generals reports and the health consequences of smoking?

A. Yes ma'am.

Q. What years?

A. Well as you know my now I'm very bad at numbers but I read the report of 1964 unless somebody wants to correct me.

Q. That's the one by Terry?

A. Lubing he understood Terry first one I've read that couple times I read it back when it first came out and I've read it recently and the same can be said of 1982 I think it's 82 or 84. Parts of the 84 report but not all of it.

Q. Do you remember what the title of the 82 or 84 report was that you are referring to or what --

A. There were two and I can't remember which ones were which and I recall one in the '80s was on the health consequences of smoking cancer and the other was on the health consequences of smoking and it was I forgot the rest of the title but I think it was in the title is chronic pulmonary lung disease. They didn't use the term chronic obstructive lung disease but chronic obstructive lung disease they didn't call it pulmonary.

Q. Did you see any evidence of chronic obstructive pulmonary disease in Ms. Hen?

A. No, I didn't have any of her lung tissue to exam.

Q. Did you see any evidence clinically of con cribbing obstruct I have lung disease?

A. Well I didn't review the records closely

to make a judgment there so I would have to defer.

Q. Do you consider bronchitis to be a subset of chronic lung disease?

A. Bronchitis is one of the two principal categories of chronic obstruct I have pulmonary disease or lung disease.

Q. Do you believe based on what you

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described earlier in the mild inflation of the left bronchi that Ms. Hen had bronchitis?

A. No ma'am. I think that the observation of bronchitis when you look at the bronchus whether you are a pull nothing or pathologist has nothing to do with chronic obstructive lung disease. Chronic obstructive lung disease is defined functionally. Is defined as the presence of the chronic cough {lasting|harassing} for more than two years and producing phlegm for at least three months in each of the two years. That's a purely clinical definition so that when we pathologists or when a pulmonologist looking at the -- or surgeon looking at the bronchus says there's chronic bronchitis he doesn't mean the patient has chronic bronchitis as defined by the American thoracic society.

Q. And I understood you to say that you don't have an opinion whether Ms. Henly has chronic

obstruct I have lung disease clinically diagnosed?

A. That's correct.

Q. Okay. Did you see any evidence of Ms. Henly having emphysema?

A. No as I said we did not have lung tissue to examine.

Q. Did you see any evidence of Ms. Henly having emphysema as seen on CT scan?

A. No. Let me just say. I don't specifically recall that everybody mentioned. It might have been. Whether it was mentioned or it didn't would not necessarily influence my judgment.

Q. Did you review any pulmonary function tests in this case?

A. In only a cursory fashion and I didn't draw any conclusions from them.

Q. Do you know what facility those pulmonary function tests were done in?

A. No ma'am I don't even specifically recall reviewing all function tests on this patient it was a very cursory examination because it did not have anything to do with my opinions expressed here today.

Q. Okay. I think you indicated that you thought that doctor coupe was the best surgeon

general in this countries had; is that correct?

A. Well, in modern times I have a very high regard for doctor coupe as a physician and as a public serveant.

Q. Do you know him personally?

A. No I've never met him.

Q. Have you known any of the surgeon generals in the United States personnel?

A. Personally no I've never met a surgeon general.

Q. Do you have any criticisms of the doctors who were rendering treatment or diagnosis for Ms. Henly?

A. No, I have not formulated any opinion

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with regard to standard of care in this case.
Q. Do you remember the names of any of the depositions that we were referring to earlier beginning with your at 1990 medical malpractice case?
MR. BARRON: You can do this I hope that you try to get him to his daughter.
MS. CHABER: It's 25 after two counsel and I'm going back to one area where he had a lapse of memory to see if he has refreshed it by now I don't think that's inappropriate counsel and I don't

know why you are interrupting and wasting time you are taking more time having this discussion than the entire question.
MR. BARRON: I'm not saying it's inappropriate I wish you wouldn't try to put words in my mouth I made an offer to you out of spirit of friendliness we know he wanted to get to his daughter he's out here on the visit we mentioned the hours he spent you have a couple checks equally those hours I was going to let him no more without asking bill for further time I want to personally get him in this Christmas season to his daughter as early as possible you can keep him another 40 minutes if you want but I don't think I need to say more I think you were going to something that was relatively unimportant and I wanted to remind you of the time.
MS. CHABER: Now you are done with an answer that has to be ten time longer than the doctors answer to the question.
A. One of the other two that I couldn't recall Mr. Settle.
Q. S E T T L E?
A. Yes and I don't recall the third at the moment it will probably come to me in ten minutes

after I'm out of here.
Q. But that was one of the Tennessee cases?
A. Yes ma'am.
Q. What about the 1990 medical malpractice case that you testified in when you were represented --
A. With Mr. Rows {PWHRAT}.
Q. With Mr. Rows {PWHRAT} yes?
A. 1990. That would be --
Q. You said approximately 1990 I'm not going to hold you to the --
A. That would be -- well the defendants name was Joshua Miller M.D. and I don't recall the plaintiff's name.
Q. I'm correct that that was the occasion that you were the representing the plaintiff that was being represented not representing but you were an expert on behalf of the plaintiff that Mr. Rows {PWHRAT} was representing?
A. I'm sorry counselor I misspoke myself again the Miller case was the second one with {ROZ}

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{PWHRAT} the more recent one.
Q. Do you know what the name --
A. I'm hundred percent positive that I couldn't remember it.

Q. You can't remember the name of the case either the plaintiff or the defendant in the case where you were retained as an expert by Mr. {ROZ} {PWHRAT} on behalf of the plaintiff?
A. There were many defendants and like six or seven and I just don't remember them.
Q. Was there a hospital facility involved {FRPLT} yes?
Q. Do you remember what hospital it was?
A. South Miami hospital.
Q. Were they a defendant?
A. I don't recall if the hospital per se was a defendant or one of its departments I just don't remember.
Q. All right. Thank you 2 dole coal 31 p.m.

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